Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION
SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
RECIPIENT	IM	A	123456739Ø	87

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. PERFORMING, M.S.	12345678	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I.M. REFERRING

A. ☐ Physical Therapy SOI ☐ Occupational Therapy SOI ☑ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems. Indicate the functional regression which has occurred and the potential to reachieve the previous skill.

CEREBRAL PALSY SINCE BIRTH. SUFFERS FROM VASCULAR HYPERTENSION, DEGENERATIVE JOINT DISEASE, DIVERTICLOSIS OF COLON, SUBACUTE CHOLECYSTIS AND CHOLELITHIASIS.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness.
MM/DD/YY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. I.M. Prescribing — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — mm/DD/YY Date

G. I.M. Performing — Signature of Therapist Providing Treatment Providing Evaluation/Treatment — mm/DD/YY Date